# INTERNATIONAL COOPERATION ADMINISTRATION

## OFFICE OF THE DIRECTOR

Washington 25, D. C.

NOV 15 1955

Mr. Allen Dulles
Director, Central Intelligence Agency
Washington 25, D. C.

Dear Allen:

In accordance with our telephone conversation, there is attached a copy of the letter from Dr. Howard Rusk containing his proposal for a Latin-American Rehabilitation Project.

As you will surmise, Dr. Rusk's idea was rather favorably viewed by Governor Stassen, but it was not implemented in FY 1955 because of a shortage of funds.

Technically, we do not rate projects of this kind very high in the scheme of priorities which has been agreed to, not only by our medical staff but by the Public Health Service, the Children's Bureau of HEW and our Health Advisory Committee. This kind of activity is, indeed, listed eighth in the third priority group (see attached paper entitled "Priorities in International Technical Assistance Health Programs"). We are far from giving adequate coverage to first priority programs, not to mention the second priorities. In view of our limited resources we are, therefore, most reluctant to undertake a project so far down the line in the third priority group.

I would be most grateful for any ideas you may have after considering the attached material.

Sincerely yours,

H. Gerald

Deputy Director
for Operations

Attachments:
Letter to Gov. Stassen
from Dr. Rusk, March 23, 1955
"Priorities in International
Technical Assistance Health Program"

State Department review completed

DEC 22 1955

Mr. D. A. FitzGerald
Deputy Director for Operations
International Cooperation Administration
Washington 25, D. C.

Dear Fitz:

Your letter of the fifteenth of November, and Dr. Burke's proposal regarding rehabilitation in Latin America have been discussed by responsible members of my staff. While the proposal has much merit and could contribute to the well-being of many persons in a crucial area, the project does not currently fit directly into our operational plans. If, however, your agency decides that its budgetary and priority requirements do permit approval as an ICA operation, we would appreciate an opportunity to discuss possible coordination of the project with a number of our activities that relate to it.

Sincerely,

SIGNED

Allen W. Dulles
Director

ILLEGIB

C/IO/Meyer:mvs (16 December 1955)
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The New York Times
Times Square

International Society
for the Welfare of
Cripples
127 East 52 Street
New York 22, New York
March 23, 1955

My dear Mr. Stassen:

Following a series of most satisfactory discussions with Drs. Hanlon and Williams, I am pleased to submit to you the following proposal for a Latin-American Rehabilitation Project to be undertaken jointly by the Foreign Operations Administration and the International Society for the Welfare of Cripples.

1. The International Society for the Welfare of Cripples is a federation of over 100 voluntary organizations conducting programs for the welfare of the physically handicapped in thirty nations. Its headquarters are at 127 East 52nd Street, New York 22, New York. The International Society has consultative status as a non-governmental organization with the United Nations and works co-operatively with many international organizations, such as the International Union for Child Welfare, World Council for the Blind, and the World Veterans Federation, in its activities.

The fundamental purpose of the ~~International Society~~ is to make possible the most effective services to assist the disabled throughout ~~the world~~. The principle method of operation is the stimulation and development of local and national voluntary organizations concerned with rehabilitation of the handicapped within the various nations. Currently, the International Society has member affiliates and close relationships in Brazil, Mexico, Argentina, Venezuela, Haiti, Chile, Cuba, Columbia, and Uruguay. Attached is a list of the names and addresses of each of these organizations. The programs of each of these countries are in various stages of development, but in each there is a formal voluntary organization which is providing some type of direct or indirect services for the rehabilitation of the handicapped.

The International Society for the Welfare of Cripples has also developed close working relationships over the years with professional persons and citizens interested in rehabilitation in several other Latin-American countries, such as Bolivia, Guatemala and Ecuador and has been in close contact with the development and implementation of the United Nations Technical Assistance Programs which has aided in the development of rehabilitation services in Guatemala and Venezuela. The International Society has also had limited working relationships with professional persons and citizens interested in rehabilitation in Costa Rica, Peru and Paraguay.

In the development of its services both to its affiliates in Latin-America and to professional persons and citizens interested in rehabilitation in those nations in which the International Society currently has no member affiliate, the International Society has worked closely with such voluntary organizations as the Rockefeller Foundation and the Kellogg Foundation and with such professional groups as the World Confederation for Physical Therapy. Dr. Hanlon and Dr. Williams are familiar with the close relationship between the International Society and Mr. David Amato, Rehabilitation Consultant, Institute of Inter-American Affairs in Mexico.

2. It is proposed that the Foreign Operations Administration and the International Society for the Welfare of Cripples undertake a joint project for a period of three years to stimulate the development of rehabilitation services for the physically handicapped in Central and South America. The basic plan is to

a. Provide a consultant and/or consultants to aid in the formation and development of voluntary agencies concerned with rehabilitation and services to the handicapped in those nations where such national, voluntary organizations do not now exist and to aid these new and currently existing organizations to develop the organizational, administrative and legislative phases of their programs. In addition, technical consultations through the use of publications, films and other media will be provided not only on the medical aspects of rehabilitation, but also on educational, social, psychological and vocational services for the physically handicapped. All consultations and planning would be done in cooperation with the Health and Welfare Services of international governmental and non-governmental organizations and national governmental and non-governmental organizations.

It is envisioned that the consultant and/or consultants would establish a headquarters in one of the Latin-American cities and from that headquarters would visit the various nations for a period from two to six weeks to consult with government officials, voluntary associations, professional organizations and others interested in rehabilitation. Local coordination of activities would be arranged through the Foreign Operations Administration Mission in each of these nations or a body designated by the Foreign Operations Administration and the voluntary, national affiliate or an organization so designated by the International Society for the Welfare of Cripples. It is proposed that the consultant and/or consultants assigned to this project be an individual with experience in the organizational and administrative phases of the development of both governmental and non-governmental programs of rehabilitation services for the physically handicapped and be a person of sufficient professional training and experience to provide technical consultations either directly or indirectly on the medical, social, educational and vocational aspects of rehabilitation services for

the handicapped.

b. The International Society will provide technical supervision for the consultant and/or consultants and as a part of the Society's regular service will provide printed materials, films and other supportive services. For example, from funds now available, the International Society is prepared to undertake translation and distribution of general and technical publications in the Spanish and Portuguese languages for distribution in Latin America.

3. To carry out this proposed project, it is requested that a contract be established between the Foreign Operations Administration and the International Society for the Welfare of Cripples under which the F.O.A. would provide a total of $22,000 annually to finance the project with the following budget:

| | Annual | Three Years |
|---|---|---|
| Salary for consultants | $12,000 | $36,000 |
| Travel costs | 7,000 | 21,000 |
| Office supplies etc. | 1,000 | 3,000 |
| Administration (10%) | 2,000 | 6,000 |
| Total | $22,000 | $66,000 |

Sincerely,

Howard A. Rusk, M.D.
President, International
Society for the Welfare of
Cripples.

Attachment

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Associacao de Assistencia a Crianca Defituosa
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Mrs. Elvira de Saldarriaga
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Sister Joan Margaret
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Dr. Carlos A. Orellana
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Miss Renee Lusiardo
National Association for Crippled Children
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# PRIORITIES IN INTERNATIONAL TECHNICAL ASSISTANCE HEALTH PROGRAMS

Joint Statement by the
Public Health Division of the
FOREIGN OPERATIONS ADMINISTRATION
and the
Public Health Service and Children's Bureau of the
U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

## Need for Priorities

Some system of priorities in health technical assistance to underdeveloped countries is essential since health needs are so vast and the resources in funds and trained personnel are so limited. The establishment of such priorities has been given attention, but not solved, by the World Health Organization and other multilateral agencies. Widely differing conditions, needs, and resources in different countries, varying motivations by governments in requesting assistance, and diverse backgrounds and viewpoints of health technicians in the field all complicate the pattern of suggested projects for each country.

In the rush in which the U. S. bilateral technical assistance programs developed, the drive was to recruit effective and experienced personnel, to supply them with the means for getting things done, and to obtain early results. There was little time for careful thought, little experience to draw on, and pressures were great from all sides.

More recently, there has been time for stock taking. The evaluation of the Institute of Inter-American Affairs' program by the Public Health Service was a major step in this direction. This study emphasizes the importance of orderly planning at the country level but does not provide a framework of over-all health priorities--an approach which is badly needed for the globe-girdling health program in which the United States is now involved.

Such a program must be based on a clear--the clearest possible--understanding of all the elements concerned in it. It must be shaped with thought, not luck. Depending for success upon cooperation with other governments, it must shape itself to their wishes but must also avoid giving way to inadvisable expediency.

## Development of the Statement

The priorities statement which follows represents the results of thoughtful consideration of the matter by experienced workers in the international health field, crystallized in a three-day conference of professional

personnel of the Public Health Division of the Foreign Operations Administration, the Division of International Health of the Public Health Service, and the Division of International Cooperation of the Children's Bureau. This group consisted of 12 individuals and included experienced members of the major public health disciplines. One or another member of the group had worked in or visited officially every country in which U. S. technical assistance programs are being conducted.

At this meeting, the first step was to consider certain elemental questions. What are the purposes and aims of U. S. technical assistance programs? Is there really a need and place for health activities in the technical assistance programs? If so, what are they and why? Discussion of these questions occupied about a full day and the result is very briefly summarized in the first paragraph of the attached document.

The various bases on which health activities in technical assistance programs should be chosen and judged were then discussed, keeping the general program goals and justifications in the first paragraph constantly in mind. It was felt by all that we are working in these countries for only a limited period of time; that our basic purpose is to show other countries how they may do the job themselves rather than for us to step in and try to do the job for them; that for many reasons we should favor activities that could affect the welfare of large numbers of the people and do so within a relatively brief interval of time; and, that while a great many health activities are theoretically or actually desirable; certain of them are impractical for technical or scientific reasons and certain others because of administrative or cultural difficulties.

In the course of the discussion, a rather interesting chart was developed for a rough classification of various program elements. Down one axis were listed the various types of activities in the field of public health, sanitation, professional education, etc., that had previously been suggested, engaged in, or might conceivably be suggested. Across the other axis were listed a series of criteria, some of which have been referred to above; economic impact, political impact, technical feasibility in the light of present-day scientific knowledge, administrative feasibility, cultural acceptability, early recognizable results, results in relation to cost, take-over ability by host country, and number of persons affected.

There followed careful discussion of each possible activity in relation to each criterion. Each activity was then rated under each criterion from zero to four plus. As a result, for the first time, it was possible to step back and look at activities in international technical assistance in health from an over-all, objective, yet relative view.

Priority Categories

From the consensus developed on each type of project as shown on the chart, the results seemed to fall into three broad categories of priorities:

1. Certain activities or programs which were always and unquestionably justified wherever the related problem existed,

2. Certain activities or programs to which we would ordinarily not react particularly favorably in the absence of special precise explanation and justification,

3. Certain activities or programs which it was definitely felt were not justified and should not be engaged in by our technical assistance programs. In this latter case, it was recognized that in rare instances certain peculiar non-health considerations might result in a decision to engage in one of these activities.

The group recognized fully that any such priority grouping would not be subscribed to in every detail by all health technicians in all country programs. Application of the list must be related to country conditions and the stage of development of the country's resources and health administration. Because of this, each of the FOA health program chiefs has been urged to go through the same evaluation and program development analysis in terms of the problems and situations peculiar to the country in which he is working. Despite its limitations, however, it is believed that thoughtful application of this document to program plans on a country-by-country basis is resulting in a more consistent policy and greater effectiveness in attaining the objectives of the technical assistance program.

Review and Revision

Subsequent to its original issuance in August 1953, this priorities statement was reviewed and discussed by the FOA Health Advisory Committee at its first meeting in March 1954. The Committee gave general approval to the document, suggesting only a few changes. The present statement includes revisions based on the views of the Committee.

## STATEMENT OF PRIORITIES

General Principles

Priorities are based on demonstrated ability of a health program to:

Strengthen economy by health benefits which release effective human energy, improve citizen morale, improve environment for local and foreign investment, open new land and project areas;

Contribute to our political objectives by reaching large populations with highly welcomed personal service programs; by demonstrating our deep human interest in man and his dignity.

In determining priority, the following factors have been weighed, recognizing considerable country variation:

a. technical and administrative feasibility
b. early recognizable results
c. results attainable relative to cost
d. take-over ability by host country
e. number of persons affected

In applying the priorities, the mission will take into account local economic, political, and cultural factors and the relationship of each project to the current health administration and to the long-range health program of the country.

Within each of the three priority groups which follow, the numerical order is not intended to indicate priority within the group.

First Priority Programs

1. Mass campaigns against malaria and yaws, where they are major problems, and against selected gross nutritional deficiencies such as kwashiorkor, beri-beri, xerophthalmia and goiter, where they may be readily attacked.

2. Development of protected small community water supplies.

3. Demonstrations through health centers of services on a community-wide basis including sanitation, communicable disease control, health records and statistics, home visiting, maternal and child health, nutrition, health education, laboratory, and general clinical services where required to gain acceptance of the community. Health centers should be used for sub-professional training and field experience for professionals and should be limited in scope and number to the national capacity to absorb and operate them.

4. Advice and assistance in strengthening and lending stability to the organization and operation of public health administration of the host government.

5. Inclusion of training and health service projects in proposed or existing community or village development programs.

6. Advice and assistance in planning and designing, and supervision of construction, of hospitals, health centers, laboratories and other health facilities.

7. Development and support of basic training of nurses to demonstrate the proper status of nursing as a profession and to provide leadership for indigenous training.

8. Training of sub-professionals to meet major specific health problems in preventive medicine, nursing, sanitation, limited medical services; such training to develop personnel for a planned program which must include professional supervision and periodic refresher training. Where practicable, opportunity should be given for advancement of outstanding individuals to higher levels.

9. Fellowships in public health, preferably project related, in U. S., not necessarily limited to one year, awarded to physicians, engineers, nurses, health educators, laboratory technicians, public health statisticians, and administrators. Training should be provided in the host country or region to the maximum extent possible.

10. Programs for training key medical school teachers in major clinical and pre-clinical specialties. Training should be provided in the host country or region to the maximum extent possible.

11. Construction of demonstration health centers and nursing schools when necessary to success of these programs by insuring physically adequate, effectively planned facilities.

Second Priority

These projects require special explanation showing economic and political values, feasibility and relationship to total health program.

1. Mass campaigns against other diseases where of major importance; e.g., trachoma, louse-borne typhus, leprosy.

2. Consultation on urban water or sewerage system.

3. X-ray, audio-visual, or other major equipment for hospitals or health centers.

4. Excreta disposal projects, other than as an integral part of a community general sanitation program.

5. Refuse disposal, fly control, and food protection projects.

6. Assignment of U. S. personnel to foreign institutions, except on a short-term consultation basis (3 months or less).

7. Occupational health services.

8. Projects for tuberculosis immunization (B.C.G.), case-finding, and ambulatory treatment, where the problem warrants and facilities permit.

Third Priority

The following types of projects, which have been suggested from time to time, have too low a priority under FOA objectives to be undertaken within available funds, except when fully justified by most unusual circumstances:

1. Mobile clinics requiring specialized motor equipment, or for general medical care
2. Construction or financing of construction of hospitals, water and sewerage systems, or other major structures
3. Operation of hospitals by U. S. personnel or at U. S. expense
4. Training of practicing physicians in clinical specialties in U. S.
5. Dental health projects
6. Mental hygiene projects
7. Establishment, equipping, or operation of blood banks
8. Medical rehabilitation projects
9. Mass treatment for intestinal parasites
10. Geriatrics projects
11. Poliomyelitis control or treatment projects
12. Training in tropical medicine in U. S.

## POLICY ON SUPPLIES AND EQUIPMENT

Purchase of such items from FOA health funds is justifiable only when

1. Necessary to effectiveness of a technician;
2. Necessary to make an important demonstration complete and convincing, or to initiate or complete a major control project;
3. Many people are reached through use in a training project.

## BASIC HEALTH TEAM

The basic health team of a mission, to accomplish the desired objectives, must include a public health physician, nurse, sanitary engineer, health educator, and health administrator.

# ROUTING AND RECORD SHEET

**INSTRUCTIONS:** Officer designations should be used in the "TO" column. Under each comment a line should be drawn [illegible] sheet and each comment numbered to correspond with the number in the "TO" column. Each officer should initial (check mark [illegible] cient) before further routing. This Routing and Record Sheet should be returned to Registry.

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